The General Practitioner in Industrial Medicine

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• Most industrial injuries are treated by physicians who have a general practice in addition to their industrial work. Because of the increasing number and seriousness of industrial injuries, better preparation for treatment is required in the patient's interest and for reasonable economy. The trend toward centralization of industrial medical facilities, increasing before and during World War II, has been somewhat reversed; the general practitioner now has an opportunity to take a useful place in the care of injured employees.

A physician dealing with industrial cases must be prepared to give immediate emergency treatment, to comply with the procedures of insurance carriers, and to refer cases which he is not skilled or equipped to handle. As a personal physician having the confidence of the patient he can secure greater cooperation from all parties concerned in industrial disability and can sometimes promote a more rapid recovery.

OF THE MORE THAN 500,000 industrial injuries reported by California physicians each year, over 60 per cent are treated by general practitioners. This latter designation includes a large number of physicians and surgeons with a general practice which is more than 50 per cent industrial.

At the time California's present workmen's compensation law was passed, the "family physician" or general practitioner treated practically all injuries, occasionally referring a case of major trauma. Today it is safe to say that most major injuries are treated by specialists or in consultation with them. This change has been brought about by the evolution of medical practice and also by certain developments in industry:

1. Increased amount of industry, with a greater number of accidents.

2. Expansion of those industries which have a higher rate of accidents.

3. Increased mechanization and speed, causing greater severity of accidents despite safety programs.

4. Increased motorization in industry and faster transportation, resulting in a greater number of vehicular accidents.

More definite treatment, demanding special skill and training, was required for the more severe and numerous injuries resulting from these conditions. Facilities beyond those available to the general practitioner are usually mandatory in major injuries.

Industrial insurors were quick to recognize this need as it became necessary for them to set up panels of physicians who they knew were qualified and equipped for industrial practice. In turn, physicians acquiring large industrial practices set up clinics, groups and other organizations which operated economically for the insurors and therefore for employers also. Many general practitioners, however, instead of qualifying themselves and making satisfactory arrangements for such practice, merely disapproved or condemned these developments. At the beginning of World War II, therefore, most industrial practice was being done by industrial groups, plant medical staffs, and even in industrial hospitals, and the medical and surgical service provided was usually good. In some instances the war enhanced these conditions; but after the war, possibly because of the opposition of organized medicine to socialization, there was a greater decentralization of industrial practice.

Nevertheless the average general practitioner, especially if he had had military service, learned from wartime conditions the value of integration, locally and regionally, of the medical profession including all specialties. With the organization of the Academy of General Practice there has developed a real effort at an equitable, honest and realistic solution to the problem of privileges and recognition of general practitioners.

Too many general practitioners formerly—as perhaps a few still do—looked upon insurance cases as an easy and inconspicuous means of enhancing their finances by padding accounts, ordering useless or unnecessary prolonged diathermy and heat treatments without supervision and billing these as physical therapy, and treating conditions for which they lacked experience and training, rather than following the concept, "as a conscientious disciple of Hippocrates, earning a reasonable living, with a security for old age and not expecting or trying to become a wealthy man through the practice of medicine." Too

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often they permitted themselves to become indolent, making no attempt to keep up with medical developments, especially in treating trauma, forgetting much and acquiring nothing to replace it. As more and better trained specialists became available—particularly in the fields of orthopedics and traumatology—employers, insurance carriers, and employees preferred and demanded this specialized service.

With the ever increasing number of accidents, both civilian and occupational, it behooved insurance companies and employers to pay heed to the type of medical service available and rendered. The cost for treatment of all accidents in 1951 was $7,900,000,000 and for that of occupational or industrial accidents was $2,650,000,000.

Can scientific treatment be compatible with compassion? It has been stated that physicians today know more about medicine than they do about patients. The author believes that in this regard the general practitioner has a place in medical and industrial integration, whether it be local, regional, or governmental, including the application of health insurance. He can well be the herald and exponent of good medicine and, at the same time, may be especially useful in psychologically evaluating the patient as a person.

The general practitioner can have a special position in the community of industry because of his intimate knowledge of the home environment and living conditions of the worker. In recent years employers in both large and small plants have taken an increasing interest in the health problems of their employees which extends to their homes. Claim examiners have long known the relation of home conditions to frequency and severity of injury. As was indicated in the discussions of the Annual Congress on Industrial Health, 1953, industrial medical and health organizations are much concerned as to the ability of the general practitioner to extend the scope of his service to the health problems of industry.

In order to render such services, however, a physician must have an office prepared for immediate emergency treatment and must make personnel in his office familiar with the forms and procedures of insurance practice. He must acquaint himself with the problems of his industrial community. He must be able to provide good modern treatment of trauma, either by his own skill and training or by definite arrangements with specialists who he knows can handle the more difficult problems for which the general practitioner is not trained. He must recognize his own limitations in accordance with the Principles of Medical Ethics, bearing in mind the objective of getting injured workers back to the job in the shortest time and with the best physical recovery.

It is not uncommon that an injured employee is seen by more consultants than are needed. They may or may not agree as to the degree of his disability, the nature of the injury and the treatment to be given, but the employee may feel that the insuror or employer is trying to find an excuse to conclude treatment or get him to work before he has fully recovered. Here the general practitioner, especially if he is the employee's personal physician, can be of great value in advising him, and often the period of disability is considerably reduced because of this personal relationship. Here is an opportunity for a real personal physician, or, to use the term of the Alameda-Contra Costa Medical Association, the patient's medical manager.

The personal physician need not fear to lose income by proper and necessary referrals. The specialist should likewise respect the Principles of Medical Ethics by seeing that the patient is returned to the care of the referring physician after the required special service has been rendered, and the insurance carriers also must respect this principle.

It may appear that this procedure involves dual service and cost, but in reality there is no additional expense. The general practitioner is simply receiving his share and recognition of the service rendered. In these times when medicine is striving for better public relations, such an arrangement will further that purpose.

The controversial problem of fee-splitting is pertinent to this discussion. There is a movement in Iowa and in Illinois to revise medical ethics in those states to permit a division of fees between the referring physician and the specialist, and there has been some indication of a similar tendency in New York and in California. This action is here mentioned only to be condemned; such a radical change is not necessary for an equitable fee, or to compensate both the referring physician and the specialist. The American Medical Association and the American College of Surgeons have long condemned fee-splitting.

The general practitioner has a very definite place in the field of industrial medicine and surgery. He cannot expect to participate without adequate training and proper facilities, and he should make known by precept and practice his willingness to call consultation whenever it seems in the best interest of the patient.

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